

No. 2
13-40
17-39
K23159

FILED AUG 10 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **24658**

Registration District No. **85**

Primary Registration District No. **1001**

Registrar's No. **782**

1. PLACE OF DEATH:
 (a) County **BUCHANAN**
 (b) City or town **ST. JOSEPH**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **STATE HOSPITAL No. 2**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: **27 yrs & 10 mo.**
 In this community **27 yrs & 10 mo.**
 years, months or days

3. (a) PRINT FULL NAME **Mrs. NINA High shoe 200**
 (b) If veteran, name war
 (c) Social Security No. **home**

4. Sex **Female** 5. Color or race **white**
 6. (a) Single, widowed, married, divorced **married**
 (b) Name of husband or wife **Mr. C. F. High shoe**
 (c) Age of husband or wife if alive **not known** years
 7. Birth date of deceased **not known 1876?**
 (Month) (Day) (Year)

8. AGE: Years **64** Months **not known** Days **not known**
 If less than one day hr. min.

9. Birthplace **American** (City, town, or county) (State or foreign country) **9**

10. Usual occupation **House wife** **9**

11. Industry or business **none** **9**

MOTHER FATHER
 12. Name **not known**
 13. Birthplace **not known** (City, town, or county) (State or foreign country) **9**
 14. Maiden name **not known**
 15. Birthplace **not known** (City, town, or county) (State or foreign country)

16. (a) Informant **Hospital Records**
 (b) Address **state hospital #2**

17. (a) **Burial** (b) Date thereof **7-24-1940**
 (Month) (Day) (Year)
 (c) Place: burial or cremation **St. Joseph, Missouri, St. Hospital #2, St. Jos.**

18. (a) Signature of funeral director **Walter Meerschopper**
 (b) Address **1302 Faraon St. St. Joseph, Mo.**

19. (a) **7/24/40** (b) **N. J. Neath**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Wade**
 (c) City or town **Mayville**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **not known**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **July** day **18**
 year **1940** hour **11** minute **P** M.
 21. I hereby certify that I attended the deceased from **July 8**
 1940, to **July 18**, 1940;
 that I last saw her alive on **July 18**, 1940,
 and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of the**
Stomach
(Primary Pancreas)
 Due to **if b**
 Due to

Other conditions **Toxic nodular Goiter** **since 1912**
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations
 Of autopsy **Arteriosclerotic**
Heart disease
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: **no**
 (a) Accident, suicide, or homicide (specify)
 (b) Date of occurrence

(c) "Where did injury occur?" (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 Mo. **St. Joseph**
 While at work? (Specify type of place)
 (e) Means of injury
 3. Signature **Herbert C. ...** (M. D. or other) **1**
 Address **State Hosp. #2** Date signed **7.25-40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

10/8 10:14 AM

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.